COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

You may request changes to your records. We will contact you within sixty (60) days of receiving your request.

CLIENT'S INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
CASE NUMBER:	SSN:	DATE OF BIRTH:

HOW DO WE REACH YOU?

PHONE NUMBER:	ADDRESS:	CITY/STATE:	ZIP CODE:

IF YOU ARE NOT THE CLIENT:

PRINT YOUR NAME:	INDICATE YOUR RELATIONSHIP TO CLIENT:

CHANGE REQUEST

WHAT INFORMATION DO YOU WANT CHANGED?

WHAT DO YOU WANT THE RECORD TO STATE INSTEAD?

WHY DO YOU BELIEVE IT NEEDS TO BE CHANGED?

SIGNATURE

SIGNATURE:	DATE: